TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-16-3823-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
August 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 06/17/2016 they denied codes E0673 and E0675, A9901. Per EOB it stated that payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

Amount in Dispute: $1,003.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to reimbursement for the set-up fee (A9901), a calf cuff (E0673), and a compression unit (E0675). The Carrier has reviewed the documentation and contends the Provider has been properly reimbursed. Reimbursement for the set-up fee is included in the reimbursement for the device being set up. The compression unit and cuff was denied reimbursed as reimbursement for these items is included in the reimbursement for the primary item, the cold therapy circulator."

Response Submitted by: The Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2016	E0673 RR, E0675 RR, A9901	$1,003.00	$901.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the requirements for preauthorization
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
   - 7 – The cost of the supply is included in the value of another procedure performed on the same date of service
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - W3 – Additional payment made on appeal/reconsideration
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
   - 293 – This procedure requires prior authorization and none was identified

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Was prior authorization required?
3. Is separate reimbursement for A9901 allowed?
4. What is the rule that applies to reimbursement?
5. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute is related to durable medical equipment. Specifically code E0675 – "Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)", and E0673 – "Segmented gradient pressure pneumatic appliance, half leg."

   The insurance carrier denied disputed services with claim adjustment reason codes 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 243 – "The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

   The carrier states in their position in pertinent part of their position, "The compression unit and cuff was denied reimbursed as reimbursement for these items is included in the reimbursement for the primary item, the cold therapy circulator."

   28 Texas Administrative Code 134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the code description for the E0675 device is used to pump compressed air into a garment placed on upper or lower extremities. The code description for E0673 indicates that the sleeve allows air to be pumped into the sleeve (compression) or air to be removed from the sleeve (decompression). The code description for the named "cold therapy circulator" is, "A water circulating cold pad with pump consists of ice water placed into a reservoir that is circulated through a pad using a mechanical pump."

The Division has determined that these are three separate items. No edits were found to prohibit payment of these services separately. The carriers' denial is therefore not supported.

2. At the time of reconsideration the carrier used additional denial codes of 15 – "Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider" and 293 – "This procedure requires prior authorization and none was identified."

   28 Texas Administrative Code §134.600 (p) (9) states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   >
   > > all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

   The billed charge for E0673 was $414.00. The billed charge for E0675 was $499.00. Neither is in excess of $500.00. This denial is not supported. Therefore, these services will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 (a)(5) states,

   > "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   The carrier denied code A9901 as "97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." Based upon the CMS Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Section 60 which states in pertinent part,

   > *Payment for Delivery and Service Charges for Durable Medical Equipment. Therefore, DME MACs may not allow separate delivery and service charges for oxygen or DME except as specifically indicated in §§90 or in rare and unusual circumstances when the delivery is not typical of the particular supplier's operation.*

   The requestor provided insufficient documentation to support that the conditions outlined in Medicare Claims Processing Manual, Chapter 20, Section 60, were met. Therefore, applicable to the above mentioned Medicare payment policy, separate payment is not recommended. The Division finds that the carriers' denial is supported.

4. 28 Texas Administrative Code §134.203 (d) (1) states in pertinent part,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > > 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule

   Review of the 2016 – 2nd Quarter Texas DMEPOS Fee Schedule www.cgsmedicare.com, finds;

   E0673-NU, $296.46 x 125% = $370.58

   The provider added the NU modifier to indicate purchase

   E0675-RR, $425.12 x 125% = $531.40

   The provider added the RR modifier to indicate rental

   Total $901.98

5. The total allowable for the services in dispute is $901.98. The carrier previously paid $0.00. Therefore, the remaining balance of $901.98 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $901.98.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $901.98, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September 29, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.